SUMMARY OF EVIDENCE

CASE OF Code A

Background/Family Observations

Code A was born in Hemel Hempstead on Code A. He was a sub-mariner in the Royal Navy and met his wife in Canada. They had three children and settled in England in 1947.

Code A suffered depression for a great deal of his life end even attempted suicide on a number of occasions. He was admitted to Knowle Hospital a number times throughout the 60's, 70's and 80's. He returned from the Navy after 22 years service and worked as a Nautical Instructor on the River Hamble. He loved sailing but when the Nautical Training School closed he lost his purpose in life and withdrew into himself. His wife died in 2001.

In about 1993/1994 Code A was admitted again to Knowle Hospital with depression. This time when he was discharged, due to the strain of caring for him at home he was discharged to Hazledene Rest Home where he lived until he died at the Gosport War Memorial Hospital on 24th January 1996.

Whilst at the Rest Home Code A became progressively worse, not socialising, refusing to eat or drink. He was then admitted to Mulberry Ward, a psychiatric ward at Gosport War Memorial Hospital. Again here he continued to deteriorate and didn't respond to treatment. Code A contracted a chest infection and was moved to Dryad Ward for terminal care. He was refusing to eat or drink. He became extremely frail and lost the will to live.

Code A was turned regularly by the nursing staff to prevent bed sores as his skin was breaking down. This caused him pain. He was therefore given morphine via a syringe driver to relieve this pain when turned. The family consider this treatment to be totally appropriate.

Code A died on 24th January 1996; his death was certified by Dr BARTON, the cause of death given as bronchopneumonia.

Police Investigation

Following the publicity in respect of the Police investigation of the case of Gladys RICHARDS who died at the Gosport War Memorial hospital in, a number of relatives of other patients who died at the same hospital reported to the Police that they had concerns in respect of the medical treatment of their relatives and requested Police investigations. Amongst these relatives were those of Code A.

The medical records of Code A were obtained by the Police, copied and submitted to the key clinical team for review. The key clinical team considered that Code A Code A 'S treatment at the Gosport War Memorial hospital was negligent and the cause of death was unclear.

As a result of the key clinical team's findings the medical records of Code A have been examined by Police in order to identify all persons who were concerned in her medical and nursing treatment. All medical and nursing staff identified have made statements explaining those entries, in the medical records of Code A, made by them or to which they made some contribution.

Case papers and the medical records of Code A have been analysed by a further set of independent experts, Dr's WILCOCK and BLACK.

Medical history of Code A

(References to page numbers are in respect of the file of medical records reviewed by the key clinical team and the set of independent experts.)

Mr Leslie Pittock had a very long history of depression as clearly set out in a summary (13). In 1959 he had reactive depression, it occurred again in 1967. In

1979 he had agitation and in 1988 agitated depression.

He had a further long admission with agitated depression in 1992 (8) complicated by an episode of cellulitis (30). This culminated in an admission to long-term residential care in January 1993 (34). He had further admissions to hospital under the care of the psychiatric team including June 1993 (37) when some impaired cognition was noted. In 1995 there was a home visit for further psychiatric problems (42).

In 1995 (44) there was a change in behaviour; loss of weight and increased frailty was noted. He was falling at the residential home. He was expressing grief, frustrations and aggression. At this time his psychiatric medications included Diazepam, Temazepam, Thioridazine, Sertraline, Lithium, and Codanthrusate for constipation. His other problems were hypothyroidism and Parkinsonism with a tremor. (Note: this was not Parkinson's disease but tremor, rigidity and akinesia which occurs similar to Parkinson's disease but as a result of long-term anti-psychotic medication).

On 29th November 1995 he was admitted under the psychiatrist Dr Banks (46) to Gosport War Memorial Elderly Mental Health beds. His mental test score was documented at 8/10 (50). He was discharged back to residential home on 24th October (46) with a continued diagnosis of depression (56). However, his very poor mobility and shuffling gate was noted (57).

On 13th December 1995 he was re-admitted (62) to mental health beds at the Gosport War Memorial under Dr Banks stating "everything is horrible". He was verbally aggressive to the staff and was not mobilising and staying in bed all day. He felt hopeless and suicidal. (62).

On 22nd December, diarrhoea started and he also had chest symptoms. It was thought he had a chest infection, and was treated with Erythromycin (64). On 27th December he was "chesty, not himself", and his bowels were causing concern. The physiotherapist noted that he had signs in his chest (65). A second course of a different antibiotic (Cephalosporin) was prescribed (81). The nursing cardex documents that he started becoming faecally incontinent on 20th December and then had further episodes of diarrhoea (140). It is also noted that by 1st January (147) he was drowsy with very poor fluid intake.

On 2nd January 1996 Dr Lord, consultant geriatrician was asked to see (66) and on 3rd January he was noted to be clinically deteriorating with poor food intake (66), albumin of 27 (67). An abdominal x-ray on 27th December describes possible "pseudo-obstruction" (116). This is a condition when the large bowel fails to work and starts to dilate, usually in patients who have multiple illnesses including Parkinsonism, electrolyte imbalance, infections, antibiotics and other drugs. Prognosis is often poor and depends on resolving the underlying causes.

On 4th January 1996 **Code A** is seen by Dr Lord, Consultant Geriatrician who noted severe depression, total dependency, catheterisation, lateral hip pressure sores

and hypoproteinaemia. (67) He states that the patient should be moved to a long-stay bed at the Gosport War Memorial Hospital and that his residential home place should be given up as he was unlikely to return. On 5th January he is transferred to Dryad Ward for "long-term care" (151). Dr Lord also states (5M) "Mrs Pittock is aware of the poor prognosis".

Gosport War Memorial Hospital

On 5th January a basic summary of the transfer is recorded, on the 9th January increasing anxiety and agitation is noted and the possibility of needing opiods is raised. The nurses cardex on 9th said that he is sweaty and has "generalised pain" (25M). On 10th January a medical decision is recorded "for TLC". In the medical discussion (13M) with the wife also apparently agrees "for TLC". I am not sure of the signature of 10th January in the medical notes (13M). The nursing cardex records they commenced Oramorph and that Mrs Pittock is aware of the poor outcome (25M).

The 15th January the nursing notes document that a syringe driver has been commenced (25M) and by the evening the patient is unresponsive (26M). However on 16th January there is some agitation when being attended to and Haloperidol is added to the syringe driver (26M). On the 17th the patient remains tense and agitated, (27M) the nursing cardex states that Dr Barton attended, reviewed and altered the dosage of medication. The syringe driver is removed at 15.30 hours and the notes say "two drivers" (27M).

The next medical note is on 18th January, eight days after previous note on 10th January. This states further deterioration, subcut analgesia continues..... try Nozinan.

On 20th January the nursing notes state that Dr Briggs was contacted regarding the drug regime and there was a verbal order to double the Nozinan and omit the Haloperidol (28M). This is confirmed in the medical notes on 20th January (15M).

On 21st January the nursing notes state "much more settled", respiratory rate of 6 per minute, not distressed.

On 24th January the date of death is verified by Staff Nurse Martin in the medical notes at 0145hrs. (15M).

Dr Jane BARTON

The doctor responsible on a day to day basis for the treatment and care of Code A was a Clinical Assistant, Dr Jane BARTON. As such her role in caring for patients is

governed by Standards of Practice and Care as outlined by the General Medical Council. This advice is sent to all doctors on a yearly basis and includes the following statements

- good clinical care must include an adequate assessment of the patients condition, based on the history and clinical signs and, if necessary, an appropriate examination
- in providing care you must keep clear, accurate, and contemporaneous patient records which report the relevant clinical findings, the decisions made, the information given to patients and any drugs or other treatment prescribed
- in providing care you must prescribe only the treatment, drugs or appliances that serve the patient's needs.

In reviewing the medical records of Code A it is apparent that Dr BARTON has not made entries in the medical records when she has visited her patient. There is lack of explanation as to the treatment being offered to Code A and the reasoning behind the various prescriptions of drugs. Ranges of drugs are prescribed which appear to fall outside recognised parameters.

Expert analysis

Dr Andrew WILCOCK

Dr WILCOCK is an expert in Palliative Medicine and Medical Oncology. He has produced two reports in respect of the cases of Code A. His first report comments on the standard of care afforded to Code A and his second report comments on the first statement of Dr Jane BARTON (referred to later).

Dr WILCOCK in his review of Dr BARTON's care of Code A reported specifically:-

i) The notes relating to Code A 's transfer to Dryad Ward are inadequate. On transfer from one service to another, a patient is usually reclerked highlighting in particular the relevant history, examination findings and any planned investigations to be carried out.

ii) Pain is the most likely reason for prescribing the non-steroidal anti-inflammatory drug (Arthrotec). However, pain was not documented in the notes, nor was any pain assessed.

iii) Code A 's painful right hand held in flexion does not appear to have been appropriately assessed. From its description it may have been tetany causing carpopedal spasm and the common causes of this should have been considered, e.g. a low serum calcium or magnesium deficiency. Less likely is a dystonia but given that some of his medications could cause extrapyramidal effects (see technical background) this possibility should also have been considered. As hypocalcaemia is reported to cause mood disturbance such as anxiety and agitation, it would have been particularly relevant to consider.

iv) It should be clarified why Dr Barton felt Code A needed opioids. From the medical notes, it appears to relate to his increasing anxiety and agitation. This is not an appropriate indication for the use of opioids. If opioids were being suggested for his painful hand, this would also be inappropriate. The medical notes state no other pain. The nursing notes do state he had generalised pain, but the lack of a full pain assessment makes it difficult to

know what pain this represented; for example, was it related to muscle and/or joint stiffness from immobility, his pressure sores or abdomen?

v) It is not clear from the medical notes the indication for which the morphine was commenced. If it was for pain then this should have been documented and assessed. It was a reasonable starting dose for someone of his age and morphine is used in palliative care for generalised pain related to muscle or joint stiffness due to immobility or painful pressure sores.

vi) It is not clear what the indications were for prescribing the syringe driver on the 10th January 1996 and for the medications it contained. It is not usually necessary to utilise the SC route unless a patient is unwilling or unable or to take medications orally (e.g. difficulty swallowing, nausea and vomiting). From the drug chart Code A did not appear to have these problems (page 18 of 49). No instructions were given on the drug chart on when the syringe driver should be commenced, how this would be decided and by whom. The dose of diamorphine was initially written as a dose range of 40–80mg, only to be subsequently rewritten the next day as 80–120mg without explanation of why a higher dose range was necessary. Based on Code A 's existing opioid dose, all of the doses of diamorphine are likely to be excessive for his needs. Given his total dose of oramorph (morphine solution) of 30mg in 24hours, an appropriate dose of diamorphine using a 1:2 or the more usual 1:3 dose conversion ratio, would have been 10–15mg in 24hours. There is no justification given for this in the medical notes. Similarly, the

indications for including the hyoscine hydrobromide and midazolam should have been documented. The dose range of midazolam of 40–80mg would generally be seen as excessive for someone of Code A 's age. However, taking into account he was a long term user of benzodiazepines, a higher than usual starting dose would likely be necessary.

vii) The dose of diazepam was increased on the 11th January 1996 with no mention of this in the medical notes.

viii) The sertraline and lithium carbonate were discontinued on the 12th January 1996 with no mention of this in the medical notes. It was unclear if this was on the advice of the psycho geriatricians or not; my understanding is that sertraline should not be discontinued abruptly as this is associated with a withdrawal syndrome that can include anxiety, agitation and delirium. A gradual withdrawal of lithium is also advised (BNF).

ix) A syringe driver was ultimately commenced on the 15th January 1996. It is not documented why it had become necessary to give these medications via a syringe driver. Code A appeared to have been taking his oral medications and the medical entry noted that he 'will eat and drink'. There was no mention in the medical or nursing notes of pain, retained secretions, agitation or anxiety that day. If he was more drowsy and unable to take his medication it would have been reasonable, particularly if he required morphine for pain relief. However, taking into account Code A 's dose of morphine, the starting dose of diamorphine (80mg) was likely to be excessive for his needs as detailed above. The reasons for including the

hyoscine hydrobromide (400microgram) and midazolam (60mg) over 24hours was not documented. The dose of midazolam of 60mg over 24hours is an above average starting dose for somebody of Code A 's age (see technical issues). He had however, been on long term benzodiazepines and in these patients a larger than usual starting dose may be necessary.

x) On the 16th January 1996 the nursing notes reported some agitation when Mr Pittock was being attended to. Haloperidol 5mg SC over 24hours was added to the syringe driver. Haloperidol is a reasonable part of the approach to treating delirium or terminal agitation in someone of Code A 's age. It should be given with caution, given Code A 's parkinsonism, as it can cause extrapyramidal effects (see technical issues). However, it is not clear from the notes that his agitation had been assessed and hence the possible underlying causes of the agitation considered. Drugs (or their withdrawal) are one of the common causes of agitation or terminal restlessness. Of particular relevance to Code A , these would include the use of opioids, particularly in inappropriate and excessive doses, hyoscine hydrobromide and benzodiazepines (Wessex Protocol, pages 30, 34). It is possible that a reduction in the dose of diamorphine may have helped Code A 's agitation.

xi) On the 17th January 1996 the dose of diamorphine was increased to 120mg and the midazolam to 80mg SC over 24hours with no reason given in the notes. The nursing notes suggest that Code A remained tense and agitated.

There is no documentation that a medical assessment was undertaken to determine whether his being 'tense' related to muscle and joint stiffness, possible extrapyramidal effects from the haloperidol or that other causes of agitation had been considered. Again, rather than increase the diamorphine, a reduction may have been more appropriate. Similarly, the discontinuation or reduction in the dose of haloperidol, or substitution for an antipsychotic with a lower risk of causing extrapyramidal effects, e.g. levomepromazine, may have been appropriate.

The nursing notes suggest that Code A was 'bubbly' due to retained secretions and this appears to be the reason for the hyoscine hydrobromide dose being increased twice in one day from 400 to 600 microgram then to 1200microgram SC over 24hours.

xii) The medical notes entry on the 18th January 1996 suggested that Code A Code A s symptoms were difficult to control but did not document which symptoms. Levomepromazine 50mg SC over 24hours was commenced. This is an appropriate drug to use for terminal agitation when haloperidol is insufficient. The dose is in keeping with that recommended by the BNF and the Wessex Protocol. However, it would have been usual to substitute it for the haloperidol rather than use it concurrently.

Dr David BLACK

Dr BLACK is an expert in Geriatric medicine. His reporting comments on the standard of care afforded to Mr Pittock and his expert opinion reports specifically:-

> Code A was an extremely ill, frail and dependent gentleman on his admission to Gosport War Memorial Hospital and was at the end point of a chronic disease process of depression and drug related side effects that had gone back for very many years.
>
> The major problem in assessing Code A 's care is the lack of documentation. Good Medical practice (GMC 2001) states that good clinical care must include an adequate assessment of the patient's condition, based on history and symptoms and if necessary an appropriate examination".... "In providing care you must keep clear accurate legible and contemporaneous patient records which report the relevant clinical findings, the decisions made, the information given to patients and any other drugs or other treatments prescribed". The major gaps in the written notes, the lack of evidence of appropriate examinations, use of unusual drug regimes without adequate documentation in the medical notes, changes in

prescription without proper documentation, all represent poor clinical practice clinical practice to the standards set by the General Medical Council. However, by itself, these do not prove that the medical or nursing care provided to Code A was sub-optimal, negligent or criminally culpable.

In my view the drug management as Gosport was sub-optimal. There was no written justification at any stage for the high doses of Diamorphine and Midazolam written up in the drug charts and subsequently prescribed to Code A. The notes and the drug charts leave confusion as to whether at one stage there may have been three syringe drivers being used. The dose of Nozinan may have been prescribed by verbal prescription and not written up in the drug chart. Combinations of the higher than standard doses of Diamorphine and Midazolam, together with the Nozinan were very likely to have caused excessive sedation and may have shortened his life by a short period of time, that in my view would have been no more than hours to days. However, this was a dying man, the family appeared to have been appropriately involved and the patient did eventually die without distress on 24th January. While his care is sub-optimal I cannot prove it beyond reasonable doubt to be negligent or criminally culpable.

Interview of Dr Jane BARTON

Dr Jane BARTON has been a GP at the Forton Medical Centre in Gosport since 1980, having qualified a registered medical practitioner in 1972. In addition to her GP duties she took up the post of the sole Clinical Assistant in elderly medicine at the Gosport War Memorial hospital in 1988. She resigned from that post in April 2000.

On Thursday 3rd March 2005 Dr BARTON, in company with her solicitor, Mr BARKER, voluntarily attended Hampshire Police Support Headquarters at Netley where she was interviewed on tape and under caution in respect of her treatment of Code A Code A at the Gosport War Memorial hospital. The interviewing officers were DC Code A and DC Code A.

The interview commenced at 0915 and lasted for 25 minutes. During this interview Dr BARTON read a prepared statement, later produced as JB/PS/3. This statement dealt with the specific issues surrounding the care and treatment of Elsie DEVINE.

Expert response to statement of Dr BARTON

The statement of Dr Barton regarding her care and treatment of Code A was provided to Dr David BLACK on completion of his initial report on the case. He is currently reviewing the statements of Dr BARTON against his report. Although not fully completed and therefore subject to change his first draft highlights the following points.

i) Code A was admitted to Mulberry ward on 14th September 1995 and not 29th November 1995 as stated in his report (para 5.4). Dr Black also assumed incorrectly that Dr Lord was a male referring to him as 'him' (para 6.9).

ii) Paragraph 13 does imply that an external examination of Code A 's pressure area's may have been undertaken. However as in Dr Black's report (para 6.10) no general physical examination is otherwise recorded to have taken place.

The statement of Dr Barton regarding her care and treatment of Code A was also provided to Dr Andrew Wilcock on completion of his initial report on the case. Although not completed and therefore subject to change his draft highlights the following points.

Dr Barton admits to poor note keeping and proactive prescribing due to time pressures in 1996. Even with significant episodes in Code A 's care however, no entry was made. Having read Dr Barton's statement regarding Code A I believe that the main issues raised in my report (BJC 71), dated 24th April 2005, remain valid and have not yet been satisfactorily addressed due to a lack of clarity regarding:

- the nature of Code A 's pain and its possible cause(s)
- the justification for the proactive prescribing of a syringe driver containing diamorphine, hyoscine and midazolam 'just in case he needed it'
- the lack of use of 'as required' doses of the above drugs instead of, or subsequently, alongside the syringe driver
- the basis for Dr Barton's use of diamorphine specifically for the relief of agitation
- the lack of assessment of the possible cause(s) of Code A 's agitation
- how the dose of diamorphine Code A ultimately received (80mg) was calculated in a way that can be clearly related to his existing dose of opioid
- given the difficulty of controlling the symptoms, whether Dr Barton sought advice.

As some of the above points relate directly to Dr Barton's knowledge of the management of pain and other symptoms in a palliative care setting it would

be helpful if she could state what specific training she had received in relation to this. In particular, where she obtained her understanding from with regards to the indications for the use of morphine/diamorphine, the phenomenon of tolerance to opioids, the methods of determining an appropriate dose of diamorphine given a patients oral morphine dose and what prescribing guidelines she was aware of and/or followed.